Freeport Family Dental

981 W. South St.
Freeport, IL 61032
(815)235-5174

Financial Policy

Thank you for selecting us as your dental health care providers. We want you to feel comfortable in knowing that we care about our patients and want you to be involved in any treatment decisions.

Financial Agreement

Patients are expected to pay for our services at the time they are rendered. Patients who have dental insurance should pay for their estimated co-pay and any deductible at that time also.

1) Full payment for all new patients on a first visit with our providers. If you have dental insurance we require any co-payment and deductible to be paid the date of service as long as we can verify your insurance ahead of time. If we cannot verify your insurance ahead of time you will be required to pay the service in full and you will be refunded after your insurance has paid their portion.
2) As well as cash and check, we accept Visa, Mastercard and Discover. You may pay any statement balances using credit cards over the phone if you wish.
3) We accept CareCredit. This is an interest-free line of credit for health care expenses only that you can apply for either in our office or at home. Please ask any of our staff for information.
4) We mail monthly statements to all patients with an account balance of $5.00 or greater. There will be a finance charge of 18% per annum on any balance over 90 days. If your insurance company has not paid before 90 days you will be expected to pay the balance and we will refund your insurance payment when received.

Appointments

We try to maintain an efficient appointment schedule in order to keep dental care costs down for our patients. We understand that things happen and there may be a time you may not be able to keep your appointment. If our patients fail to keep their appointments or cancel at the last minute it makes it difficult for us to fill that slot and affects the cost of all our patients care. Therefore, after any patient fails to show up for two appointments, or cancels the same day as their appointment we will assess a $75.00 missed appointment fee to your account. You can leave a message on our voice mail if you call after business hours.

Insurance

We will submit claims to your insurance company for each service you are provided. Please be certain to give our office a copy of your insurance card whenever it changes so that the claims are processed correctly. You will need to check with your insurance company if you have questions about whether our doctors are in your network. Each employer group negotiates with insurance companies and we may not be in all their networks. We can assist you when needed but as the policy holder you have the better ability to deal with your insurance company. Please know that our doctors will not treat you based on your insurance coverage but on your dental health. You may ask for a treatment plan estimate that we will send to your insurance company so that you will know your responsibility ahead of time.

Delinquent Accounts

All accounts with outstanding balance which is over 90 days from the date of service will incur a finance charge of 18% per annum. In the event the account is turned over to a collection agency, the patient will be responsible for all collection fees including, but not limited to, attorney's fees and court costs. All collection fees and attorney's fees will be added to the account balance and will accrue interest at 18% per annum. If you have given us your cell phone number you give permission to receive predictive auto-dialer and prerecorded calls from a collection agency if the event your account is turned over to a collection agency.

Refunds

If your account has a credit balance you may ask for a refund. Otherwise we will carry the credit balance for use in future services.

Please indicate your understanding and acceptance of these financial policies by signing below. For the mutual convenience of you and our practices, it is understood that this executed copy of the Financial Policy also shall cover your dependent children who are patients of this practice.

_____

Patient's name

_____

Patient's signature Date

_____

Office Staff signature Date